

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2a Film 407 12/3/68 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15961

1. DECEASED NAME (Type or Print) 15947 Helen Marie Auer			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Not Known 19			2b. HOUR <input type="checkbox"/> M				
3. SEX F	4. RACE White	5. DATE OF BIRTH 11-18-05	6. AGE (In years last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month Nov. Day 17 Year 68			2d. HOUR 8P M	
7a. BIRTHPLACE (State or foreign country) Balta Co. U.S.			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford Md.	
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pathway Ave Chaste Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY Harford			13c. CITY OR TOWN Fallston			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Rural			14. FATHER'S NAME First Lewis Middle August Last Auer			15. MOTHER'S MAIDEN NAME First Annetta Middle Louise Last Snider			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16b. SOCIAL SECURITY NO. 245-529183			17. INFORMANT Mrs. H. Clara Fritzsche Fallston			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convulsive Disorder DUE TO, OR AS A CONSEQUENCE OF (b) Mental Retardation DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION 7235			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Gerald C Palmer			CHIEF MEDICAL EXAMINER <input type="checkbox"/> Beitler, MD			22b. DATE SIGNED 11-17-68				
EXAMINER'S NAME (Type) Gerald C Palmer MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov-20-1968			23c. NAME OF CEMETERY OR CREMATORY Little Fallston Friends			23d. LOCATION (City or Town) (County) (State) Fallston Harford MD	
24. FUNERAL DIRECTOR W St Archer, Benson MD			ADDRESS			25a. REC'D BY REGISTRAR NOV - 2 1968			25b. REGISTRAR'S SIGNATURE Charles Judge	

1961

1961

1961



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

15942

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18b. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
KENNETH CURTIS ASHTON					2a. DATE KNOWN OF DEATH ESTIMATED		Nov.	28	1968	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
Male	Negro	Oct. 20, 1928		40 YRS.	2c. DATE PRONOUNCED DEAD		Nov.	28	1968	6:00 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York		U.S.A.				Harford		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Edgewood		Dispensary - Edgewood Arsenal				Laborer				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
N.J.		Salem		Salem		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18 Hillside Ave.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
UNK.					Selma				Ashton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. DRUGS				
Yes		UNK.		Unknown		Francis E. Ashton		18 Hillside Ave. Salem, N.J.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>										
4270 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4341										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Gerald C. Palmer				CHIEF MEDICAL EXAMINER		Bel Air, Md.		
EXAMINER'S NAME (Type)		Gerald C. Palmer, M.D.				ASSISTANT MEDICAL EXAMINER		22b. DATE SIGNED		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Nov. 28, 1968		
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Removal		Nov. 28, 1968		Walples Funeral Home		42 Olive St. Salem		N.J.		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Howard K. McComas & Son				Abingdon, Maryland		DATE DEC 2 1968		J. Charles Judge		

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
15949											
15963											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <i>Jeannette (N.M.N.) Billhardt</i>						2a. DATE OF DEATH Month Day Year <i>11 30 68</i>			2b. HOUR <i>6:15</i> M		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Jan. 11, 1889</i>			6. AGE (In years lost birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Pa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i> Md.					
10. CITY OR TOWN OF DEATH <i>Harre-de-Grace</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md</i>				13b. COUNTY <i>Cecil Perryville</i>		13c. CITY OR TOWN <i>Mill Creek</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <i>William Fulton</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Kathryn Kline</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>				16b. SOCIAL SECURITY NO. <i>548-44-5730</i>		17. INFORMANT <i>Mrs. Virginia B. Emey, Perryville, Md.</i>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <i>Generalized Arteriosclerosis</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic Cardiovascular Disease</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>11-22, 1968</i> , to <i>11-30, 1968</i> , that (I) (we) last saw the deceased alive on <i>11-30, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dante Monakil MD</i>						DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>11-30-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>DANTE U. MONAKIL, MD</i>						22e. ADDRESS <i>241 N. Union Ave. Harre-de-Grace, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-3-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Charles Evans Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Harford, Pa.</i>			
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>						25a. REC'D BY REGISTRAR <i>DEC 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Young</i>			

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1943-1944
1945-1946

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1945-1946

1943-1944
1945-1946

FOR STATE
HEALTH DEPT.

15950

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15964

Item #2a, Film 3406 1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First LENA			Middle MAE			Last BREWER			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year MATED <input type="checkbox"/> Unknown 19			2b. HOUR M								
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 15, 1910		6. AGE (in years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year Nov. 11 1968			2d. HOUR 1 PM								
7a. BIRTHPLACE (State or foreign country) Va.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Harford				Md.							
10. CITY OR TOWN OF DEATH Bel Air				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Henley Ave.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress				12b. KIND OF BUSINESS OR INDUSTRY Shoe											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Harford				13c. CITY OR TOWN Bel Air				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 2, Box 159, Henley Ave.									
14. FATHER'S NAME			First John			Middle --			Last Salyer			15. MOTHER'S MAIDEN NAME			First Ellen			Middle --			Last Castle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 229-32-5406				17. INFORMANT ADDRESS Douglas G. Brewer, R.D. #1, Aberdeen, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C V D 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4221																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Gerald C. Palmer						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b. DATE SIGNED Nov. 11, 1968											
EXAMINER'S NAME (Type) Gerald C. Palmer						ADDRESS (Street, city, town, or county) Bel Air, Md.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Nov. 13, 1968				23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens				23d. LOCATION (City or Town) (County) (State) Aldino Harford Md											
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.						ADDRESS						25a. REC'D BY REGISTRAR DATE NOV 13 1968				25b. REGISTRAR'S SIGNATURE Charles Judge							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

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728 2007

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Abstract

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Figure 2.20

1994年10月

[illegible]

note 1.

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c3

2002-55-025

James C. Brown, R.D. 1, Alhambra, Cal.

D-V-5-01709 (unclassified)

Received 25 May 2002

10210

1997-98, 1998-99

Admission: \$1.00 (includes lunch and drink)

9861-2, 4, 5, 6

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15951

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15965

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year			2b. HOUR								
CHARLES EDWARD BUTLER, III						Nov. ?? 9, 1968			?? M								
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR						
Male	White	Sept. 11, 1967	1 YRS. 14					Nov. ?? 9, 1968			?? M						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.					
Md.			USA						Baltimore Harford								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Joppa			UNK.														
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
Maryland			Harford			Joppa						1066 Plaza Circle					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
Charles Edward Butler, Jr.			Eunice									Catron					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
no			213-60-0464			Charles E. Butler, Jr., 1066 Plaza Circle			Joppatowne, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Blunt Force Injury to abdomen complicated by																	
988X																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:																	
(b) rupture of colon and peritonitis																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
936.9																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
				?? 19 ??				???									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town		County		State	
				??				??				??		??		??	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																	
ACTUAL SIGNATURE				Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				November 10, 1968					
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
								ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				Nov. 12, 1968				Bel Air Memorial Gardens				Bel Air Harford Md					
24. FUNERAL DIRECTOR				ADDRESS				25a. RECD BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Howard K. McComas & Son, Abingdon, Md.								NOV 13 1968				Charles Judge					

1-1950

MAINTENANCE OF RECORDS
FOR THE YEAR 1950

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ON THE
15th DAY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15952

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15952

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR			
Benjamin Saulsbury Carroll						November 18, 1968			10P. M			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		Sept. 6, 1901		67 YRS.		MONTHS DAYS		HOURS MIN.		
7a BIRTHPLACE (foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Easton, Maryland		U.S.A.				Harford County, Md.						
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Bel Air			705 Ridgewood Road			Teacher			Education			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Harford		Bel Air				705 Ridgewood Road			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Ulysses Frank Carroll			Annie Ettein									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT (Wife) 838-6055			Address 705 Ridgewood Rd				
No			219-16-4003		Mrs. Margaret W. Carroll			Bel Air, Md. 21014				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESP. FAILURE</u>											2 HRS	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ANGINA OF</u>											MANY	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (c) <u>A.S.G.U.D.</u>											YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION												
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19												
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)												
21f. LOCATION Street or R.F.D. No. City or Town County State												
22a. I certify that (I) (this hospital) attended the deceased from 1947, 19, to 19, that (I) (we) last saw the deceased alive on 18 Nov 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE <u>H. P. Sidwell M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												
22c. DATE SIGNED Nov. 19, 1968												
22d PHYSICIAN'S NAME (Type) H. Proctor Sidwell, M.D.												
22e ADDRESS 401 Franklin Street, Bel Air, Md. 21014												
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Nov. 21, 1968		Bel Air Memorial Gardens			Bel Air, Harf. Co., Md. 21014				
24. FUNERAL DIRECTOR W. Broatney & Williams												
Joseph William Foster Bel Air, Maryland 21014												
25a. FILED BY REGISTRAR NOV 20 1968												
25b. REGISTRAR'S SIGNATURE												

1961



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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15952 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15952					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year		2b. HOUR				
TRUDY			GARLAND			CASEY			Nov. 29 68		M				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			
Male		White		Mar. 24, 1951		17 YRS		MONTHS DAYS		HOURS MIN.		Month Day Year			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9 COUNTY OF DEATH			
Va.		USA										Harford Md			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace				DOA-Harford Memorial Hospital				Dipper				shoe factory			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.				Harford				Belcamp				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Belcamp Hotel	
14 FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last						
Curtis			--			Casey			Nora			-- Dye			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
no				226-74-6513				Mabis Massie, Pine Road, Joppa, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound chest															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF															
DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
176x															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
				1:00 PM Nov. 29 19 68				Shot self							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				Belcamp Hotel				City or Town County State Belcamp Harford Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				Gerald C. Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/> Be/A: m/-							
EXAMINER'S NAME (Type)				Gerald C. Palmer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED							
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 29, 1968							
								ADDRESS (Street, city, town or county) Bel Air, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY							
Removal				Nov. 30, 1968				Honaker Funeral Home							
								23d. LOCATION (City or Town) (County) (State) Honaker Russell Va.							
24 FUNERAL DIRECTOR								ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard K. McComas & Son, Abingdon, Md.										DEC 2 1968		J. Charles Judge			



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VR A15 (4)
30M REV. 1/68

15956

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1586

1. DECEASED NAME (Type or print) Baby			First	Middle	Last	2a. DATE OF DEATH Nov. Month 1 Day Year 68			2b. HOUR 1:50 M			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH OCT 31, 1968			6. AGE (In years lost birthday) — YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford					
10. CITY OR TOWN OF DEATH HAURS DE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY Harford			13c. CITY OR TOWN Beltair		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last PRICILLA ANN Charles									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Primary Atelectasis Lung 7769 DUE TO, OR AS A CONSEQUENCE OF Primaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 762.5												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 10-31 , 19 68 , to 11-1 , 19 68 , that (I) (we) lost the deceased alive on 11-1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE A. Conjero M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (Type) Aida G. Conjero						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-5-68		23c. NAME OF CEMETERY OR CREMATORY Hamden Hill Cem			23d. LOCATION (City or Town) (County) (State) Beltair Harford MD					
24. FUNERAL DIRECTOR George W Tittle		ADDRESS Beltair		25a. REC'D BY REGISTRAR NOV 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						

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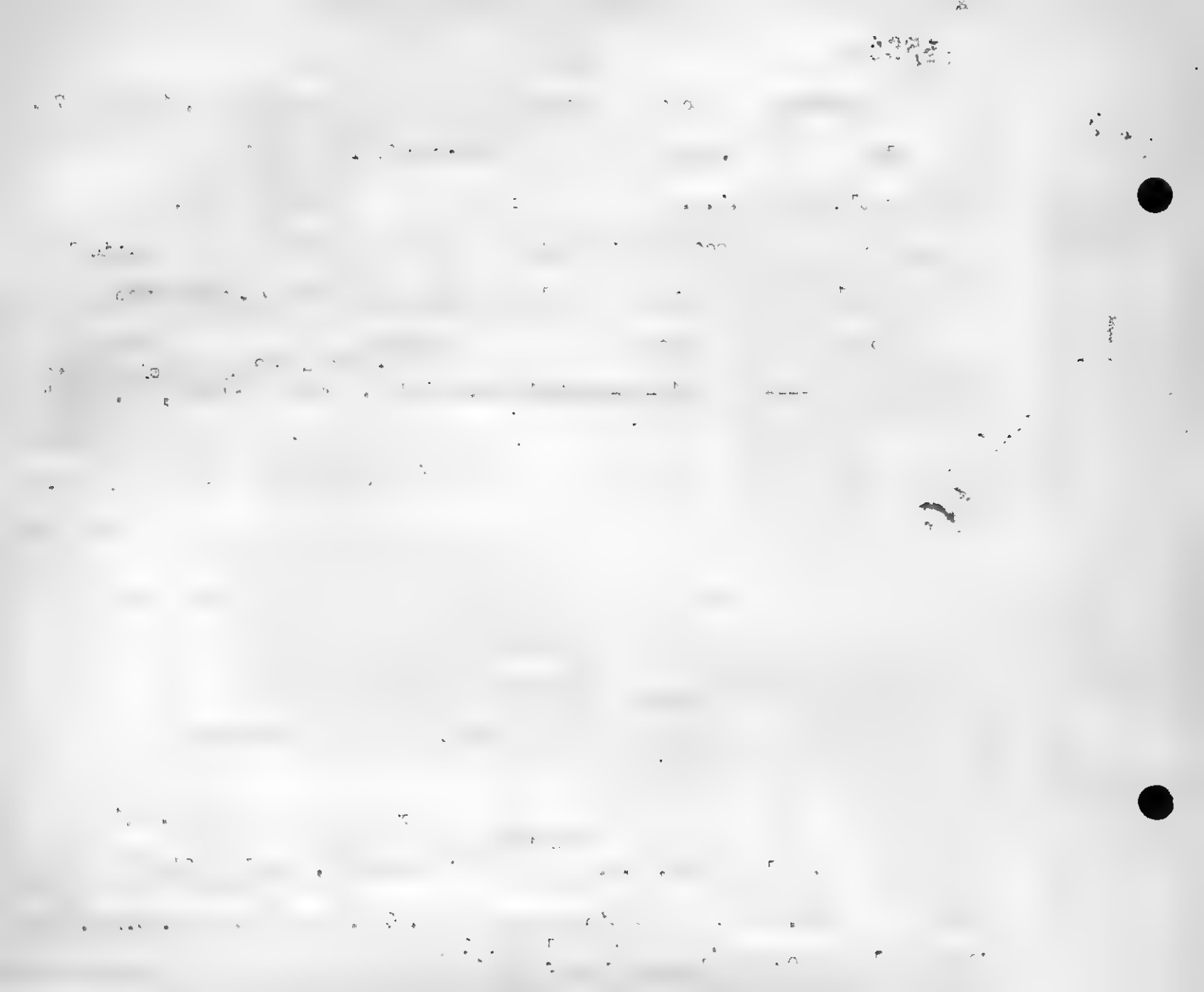
VR 415
30M REV 1-68

15955

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15769

1. DECEASED NAME (Type or print) First Middle Last Haywood Letcher Choate			2a. DATE OF DEATH Month Day Year November 20, 1968		2b. HOUR 7A. M
3. SEX Male	4. RACE White	5. DATE OF BIRTH November 3, 1877		6. AGE (in years lost birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford County, Md.	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 309 Lakeside Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer	
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 309 Lakeside Drive
14. FATHER'S NAME First Middle Last John Choate			15. MOTHER'S MAIDEN NAME First Middle Last Matilda Edwards		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) ----		16b. SOCIAL SECURITY NO 218-54-0146	17. INFORMANT (Daughter) 838-3483309 Lakeside Drive Mrs. Mabel C. Tharpe Bel Air, Md. 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Mesenteric Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic CVD Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs 6 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Oct , 19 42 , to Nov , 19 68 , that (I) (we) lost saw the deceased alive on Nov 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (us) (did) (not) view the body after death.					
22b. SIGNATURE J. Ralph Horky		DEGREE 734-7134		22c. DATE SIGNED Nov. 20, 1968	
22d. PHYSICIAN'S NAME (Type) J. Ralph Horky, M.D.		22e. ADDRESS Churchville, Maryland 21028			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 23, 1968	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Methodist Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Bel Air, Harf. Co., Md. 21014
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St.		25a. REC'D BY REGISTRAR NOV 22 1968	
		Bel Air, Maryland 21014		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR M	
Corbit							Cox		November 12 1968			3:15 A	
3. SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male			White			May 11, 1896			72 YRS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md	
N.C.			U.S.A.						Hartford				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Havre de Grace			Hartford Mem. Hosp.			Farmer			Farming				
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET AND NUMBER				
Md			Hartford			Pylesville			Box 134				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Calvin Cox			Ennice Crouse										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address				
Yes			WW I			217-12-7128			Mrs. Verna Cox			Box 134 Pylesville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Decompensation												6 days	
DUE TO, OR AS A CONSEQUENCE OF A.S.C.V.D.												2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Paroxysmal Ventricular Tachycardia and Cardiac Arrest													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11-7-68, 1968, to 11-12, 1968, that (I) (we) last saw the deceased alive on 11-12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS				
Edward C. Loo, M.D.			11/12/68			Edward C. Loo, M.D.			Havre de Grace, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			11/14/1968			Bel Air Mem. Gardens			Bel Air, Hartford, Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Charles E. Kurtz			Jarrettsville, Md.			DATE NOV 14 1968			j Charles Judge				

1944



1944



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the coroner's papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR-103
30M REV. 1-68

15957

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15971

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Annabelle				Crystal	November 3, 1968		10A. M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR MONTHS DAYS HOURS M.N.		
Female	White		January 1, 1906		62 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		U.S.A.				Harford County, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Fallston		2800 Bel Air Road		Housewife		Homemaker			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Harford		Fallston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2800 Bel Air Road	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Thomas Dunlap Love				Margaret Elizabeth Pitsley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT (Husband) 879-7925 2800 Bel Air Road			
No						Mr. Orest V. Crystal Fallston, Maryland 21047			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsisemia, Generalized</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary Tract Infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Colon, Metastatic</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. no. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>68</u> , to <u>Nov.</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct. 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Kermit P. Bonovich</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Nov. 3, 1968</u>			
22d. PHYSICIAN'S NAME (Type) Kermit P. Bonovich, M.D.				22e. ADDRESS Bel Air Road, Fallston, Md. 21047					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 6, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Harf. Co., Md. 21014</u>			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		W. Broadway & Williams Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR <u>NOV 6 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-7-68
30M REV. 1-68

15958

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1597

1. DECEASED NAME (Type or print)		First GARFIELD	Middle T.	Last DAVIS	2a. DATE OF DEATH Month Day Year November 3 1968		2b. HOUR 7:21 AM
3. SEX Male	4. RACE Colored		5. DATE OF BIRTH May 1, 1898		6. AGE (In years lost birthday) 70 YRS	7. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) White Hall, Md.		7b. CITIZEN OF WHAT COUNTRY? US A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Harford Grace		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Harford Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Supervisor Miss Hall		12b. KIND OF BUSINESS OR INDUSTRY A. P. S.	
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9 Monroev St.	
14. FATHER'S NAME First Middle Last Thomas Davis		15. MOTHER'S MAIDEN NAME First Middle Last Ella Walton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			
16b. SOCIAL SECURITY NO 166-12-4884A		17. INFORMANT Mrs. Sarah L. Davis, Aberdeen, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage 4319 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 dy 1 dy
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Gout							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 1968 , to 11/3/1968 , that (I) (we) lost saw the deceased alive on 11/3/1968 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William L. Woerner		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED 11/4/68			
23a. BURIAL, CREMAT., OR REMOVAL (Specify) Burial		23b. DATE 11-7-68		23c. NAME OF CEMETERY OR CREMATORY Pine Grove United Meth. Ch.		23d. LOCATION (City or Town) (County) (State) Pine Grove, Md.	
24. FUNERAL DIRECTOR Charles D. Bullock, Harford, Md.				25a. REC'D BY REGISTRAR DATE NOV 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15959

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15873

1 DECEASED-NAME (Type or Print) Robert Edward Dickson		First Middle Last		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Nov Day 26 Year 1968		2b HOUR 12:15 M
3 SEX Male	4 RACE White	5 DATE OF BIRTH 4/22/26	6 AGE (in years last birthday) 42 YRS	7 UNDER YEAR MONTHS 4 DAYS 26	8 IF UNDER 24 HRS HOURS 4 MIN 26	2c DATE PRONOUNCED DEAD Month Nov Day 26 Year 1968
7a BIRTHPLACE (State or foreign country) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md
10 CITY OR TOWN OF DEATH Harford		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford General Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD COUNTY Harford		13b CITY OR TOWN Pasadena		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Rte 11 Box 75	
14 FATHER'S NAME First Middle Last Roni Dickson			15 MOTHER'S MAIDEN NAME First Middle Last Flora Dozier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO.		17. INFORMANT Family		ADDRESS Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crush. v. injury R. Chest 119.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1254						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11-7 P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Auto Accident		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Deerfield Road, Darlington Md.		21f. LOCATION Street or R.F.D. No City or Town County State Darlington Md. Md.		
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE L. Gerald Palmer		EXAMINER'S NAME (Type) L. Gerald Palmer MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-26-68
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 11/30/68		23c NAME OF CEMETERY OR CREMATORY Glen Haven Cem		23d LOCATION (City or Town) (County) (State) Glen Burnie AA Co MD
24. FUNERAL DIRECTOR McGulley F.H. 737 Patuxent Ave		ADDRESS		25a REC'D BY REGISTRAR DEC 2 1968		25b REGISTRAR'S SIGNATURE J. Charles

2000



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-155. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15960

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15971

1. DECEASED NAME (Type or Print) WALTER		First RUSSELL		Middle FAMOUS		Last		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Nov 19 1968		2b. HOUR M	
3 SEX Male	4 RACE White	5 DATE OF BIRTH Dec. 14, 1903		6 AGE (In years last birthday) 64 YRS	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____		2c. DATE PRONOUNCED DEAD Month Nov Day 19 Year 1968		2a HOUR 10 M
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford					
10 CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Garage owner-opr.		12b KIND OF BUSINESS OR INDUSTRY auto			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Harford		13c CITY OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3108 Philadelphia Road			
14 FATHER'S NAME Parker		First --		Middle Famous		15 MOTHER'S MAIDEN NAME Rose		First --		Middle Swanner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		(If yes give war or dates of service)		16b SOCIAL SECURITY NO 218-32-1493		17. INFORMANT Lida C. Famous, 3108 Philadelphia Road		ADDRESS Abingdon, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4109											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____		State _____	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gerald C. Palmer		EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Bel Air, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Nov. 22, 1968		23c NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCAT ON (City or Town) Bel Air		(County) Harford		(State) Md	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a. DATE BY REGISTRAR NOV 21 1968		25b. REGISTRAR'S SIGNATURE James J. Young					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15961

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15875

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) SARAH RITES GALLION		2a. DATE OF DEATH Month Nov. Day 2 Year 1968		2b. HOUR 1-20 P.M.
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH JAN 28, 1892	6. AGE (In years last birthday) 76 YRS.	7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH HARFORD	
10. CITY OR TOWN OF DEATH HAURDE GRACE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife	12b. KIND OF BUSINESS OR INDUSTRY SAME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN HAURDE GRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 716 Commerce St.
14. FATHER'S NAME First HARRY Middle RITES Last SARAH	15. MOTHER'S MAIDEN NAME First SCALLY Middle Last 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO. YES	17. INFORMANT Harold Dean Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarct 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (c) Condit.ans, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC	21f. LOCATION Street or R.F.D. No City or town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1963 , to 11-2 , 19 68 , that (I) (we) last saw the deceased alive on Nov. 2 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Harold Dean		DEGREE PHYS.	ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 11-2-68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10/4/68	23c. NAME OF CEMETERY OR CREMATORY Wilmington	23d. LOCATION (City or town) (County) (State) Darlington, Harford, Md	
24. FUNERAL DIRECTOR Harold Dean Md	25a. REC'D BY REGISTRAR NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15962

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15976

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Grace WILLIAMS		George			November 09 68		3:40 AM		
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
Female	White		April 8, 1889		79 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Harford Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Harrode Grace, Md.		Citizens Nursing Home		HOUSE WORK		HOME			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Darlington, Md.		Harford		Darlington					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
ROBERT GEORGE		ELIZA STANFORD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address,					
		213-18-2098		ANNIE T. GEORGE DARLINGTON MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1830								1 day	
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF OVARY C								10 MO.	
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Metastasis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
1750									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from JAN 2, 1968, to 11/9, 1968, that (I) (we) last saw the deceased alive on 11/8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Dudley Phillips								11/9/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Dr. Dudley Phillips				Darlington, Maryland					
23a. BURIAL, CREMATION, REMOVA (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		Nov. 12, 1968		DARLINGTON, CEM.		HARFORD MD			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
R. Madison Mitchell				Harrode Grace, Md.		NOV 13 1968		J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15962

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15377

1. DECEASED-NAME (Type or print) GEORGE EARL GROSS			2a. DATE OF DEATH Month November Day 18 Year 1968			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 24, 1892		6. AGE (In years last birthday) 76 YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford				
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 505 Congress Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Baggage Agent			12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 505 Congress Ave.	
14. FATHER'S NAME First Josephus Middle -- Last Gross			15. MOTHER'S MAIDEN NAME First Ida Middle Kate Last Starleper							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes (If yes give war or dates of service) WWI			16b. SOCIAL SECURITY NO. 705-05-4479		17. INFORMANT Address Md Wendell G. Gross, 500 Edgewood Road, Edgewood					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 1564 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 11-12 , 19 67 , to 11-18 , 19 68 , that (I) (we) last saw the deceased alive on 11-18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Nov. 18, 1968		
22d. PHYSICIAN'S NAME (Type) Gunther D. Hirsch						22e. ADDRESS 131 S. Union Ave, Havre de Grace, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov. 21, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery			23d. LOCATION (City or Town) (County) (State) Sharpsburg Washington Md		
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.						25a. RECEIVED BY REGISTRAR NOV 20 1968		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) ALLAN SOUTHWORTH INGALLS					2a. DATE OF DEATH Nov Month 24 Day 68 Year			2b. HOUR 0545 M		
3 SEX Male		4. RACE White		5. DATE OF BIRTH 24 Feb 14		6 AGE (In years last birthday) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford, County Md				
10. CITY OR TOWN OF DEATH Edgewood, Arsenal			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 406 Oak Street			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Soldier		12b. KIND OF BUSINESS OR INDUSTRY US Army		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INS OR CITY, M IS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 406 Oak Street	
14. FATHER'S NAME First Middle Last WALTER BEMENT INGALLS					15. MOTHER'S MAIDEN NAME First Middle Last ALLICE NMI COLLINS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If no, no or unknown)			16b. SOCIAL SECURITY NO. 1937 - 1964 003-03-2361		17. INFORMANT Address ANNA B. INGALLS 406 Oak Street Edgewood, Md.					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable acute myocardial infarction 7109 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4241										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. B. Wilmeth MD					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 24 November 68			
22d. PHYSICIAN'S NAME (Type) J. B. WILMETH, MD					22e. ADDRESS USA DISPENSARY, EDGEWOOD ARSENAL, MD.					
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE Nov. 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Fort Myer Va				
24. FUNERAL DIRECTOR ADDRESS Howard K. McComas & Son, Abingdon, Md.					25a. REC'D BY REGISTRAR DATE NOV 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15965

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15979

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) EdNA Stevens IVINS			2a. DATE OF DEATH Month Nov. Day 13 Year 68		2b. HOUR 10:40 M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH February 5, 1886		6. AGE (In years last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford Md.		
10. CITY OR TOWN OF DEATH Harford	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.	13b. COUNTY Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 13 Mt Royal Ave.	
14. FATHER'S NAME First John Middle Franklin Last Stevens		15. MOTHER'S MAIDEN NAME First MARY Middle ANNA Last GATES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-12-6537-A		17. INFORMANT Name Harry M. Ivins, Address Aberdeen, Md. 21001	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 24 hr. (c) 24 hr.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4001					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (ths hospital) attended the deceased from 1946 , 19 11-13-68 , to 11-13-68 , that (I) (we) last saw the deceased alive on Nov 13 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Peter P. Roemer, M.D.		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 11-13-68	
22d. PHYSICIAN'S NAME (Type) Peter P. Roemer, M.D.		22e. ADDRESS 18 Low St., Aberdeen, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 16 Nov. 1968		23c. NAME OF CEMETERY OR CREMATORY Grove Presbyterian Cem.	
23d. LOCATION (City or Town) (County) (State) Aberdeen, (Harford) Maryland		24. FUNERAL DIRECTOR Barring Funeral Home		25a. REC'D BY REGISTRAR NOV 18 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					

FOR STATE
HEALTH DEPT.

15966

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15966

1 DECEASED NAME (Type or Print) Walter Keyser			2a. DATE KNOWN OF DEATH Month 11 Day 28 Year 1968			2b. HOUR M
3 SEX M	4. RACE W	5. DATE OF BIRTH 28 March 1921	6. AGE (in years last birthday) 47 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Nov. Day 28 Year 1968
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Soldier		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.
13a. USJA. RESIDENCE (Where deceased lived, if not in hospital on date of admission) STATE Pa.		13b. COUNTY Delaware	13c. CITY OR TOWN Newton Square		13e. STREET AND NUMBER 31 Northwood Rd.	
14. FATHER'S NAME First W.T.J. Middle Keyser Last (Deceased)			15. MOTHER'S MAIDEN NAME First Lura Middle Lee Last (Deceased)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 1938--1960 575-24-9058		17. INFORMANT Kathleen Dahler, Baltimore, Md. 21220		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushing injury chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year Nov 11-28 1968 6:30 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Auto accident		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) MSR + 1		21f. LOCATION Street or R.F.D. No. City or Town County State Columbia Cecil Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Gerald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-28-68		
EXAMINER'S NAME (Type) Gerald C Palmer		ADDRESS (Street, city, town or county) Tarring Funeral Home, Aberdeen, Md. 21001				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3 Dec. 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Fort Myer, Virginia		23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Walter W. Wason		ADDRESS Tarring Funeral Home, Aberdeen, Md. 21001		25a. REC'D BY REG. STRAR DATE DEC 3 1968		25b. REGISTRAR'S SIGNATURE Charles Young

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-10-10



10-10-10



10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15967

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Robert John Leamon			2a. DATE OF DEATH Month 11 Day 29 Year 68			2b. HOUR 5:30 M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH SEPT. 3, 1889		6. AGE (In years last birthday) 79 YRS.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.	
10. CITY OR TOWN OF DEATH Harre-de-Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RAILROAD ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY P.R.R.	
13a. USUAL RESIDENCE (Where deceased lived, if institution) (Residence before admission) STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Cardiff		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Strome Leamon		15. MOTHER'S MAIDEN NAME First Middle Last Annie Cash		16. SOCIAL SECURITY NO. 716-12-3825			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		17. INFORMANT Mrs. Nora P. Leamon		Address Cardiff, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration Pneumonia CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (d), STATING THE UNDERLYING CAUSE 11-17-68 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days 2 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Aspiration Pneumonia							
19a. DATE OF OPERATION 11-29-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aspiration Pneumonia		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Office Building		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-17 , 19 68 , to 11-29 , 19 68 , that (I) (we) last saw the deceased alive on 11-29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward C. Leamon		22c. DATE SIGNED 11/29/68		22d. PHYSICIAN'S NAME (Type) Edward C. Leamon, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Slate Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Delta York County, Pa.	
24. FUNERAL DIRECTOR John H. Harkins		ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR DEC 3 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jagger	

200



201



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year			2b. HOUR M
Hugh C. Manchee						2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 F UNDER YEAR	8 IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR M
Male	White	Oct. 9, 1898	70 YRS	MONTHS	DAYS	Nov. 1 1968			4:10 P.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Whiteford, Md.		USA				Harford			Md
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Whiteford			Main Street			R.N. Telegrapher			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Md.			Harford			Whiteford			Main Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Eli Manche			Ellen V. Hughes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
No			214-18-1715			Martin E. Manchee, Whiteford, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Hypertensive C V Disease									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
443X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2. a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
CAUSE OF DEATH			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Gerald C. Palmer						Bel Air, Md.			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			Nov. 2, 1968			
Gerald C. Palmer, M.D.						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			Nov. 5, 1968			Slate Ridge			Delta York Pa.
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REG STRAR			25b. REGISTRAR'S SIGNATURE
John H. Harkins			Delta, Pa.			NOV 6 1968			Charles Judge



15983

15969

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) George C. (NAN) MASLAR			2a. DATE OF DEATH Month NOV. Day 14 Year 1968			2b. HOUR 3:10 AM	
3. SEX MALE		4. RACE white		5. DATE OF BIRTH April 27-1902		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) Eschschauk 3 A		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE PA.		13b. COUNTY Beaverdale		13c. CITY OR TOWN Beaverdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 192 07 5570		17. INFORMANT Voluntarily Funeral Home Beaverdale Pa. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Failure - Congestive DUE TO, OR AS A CONSEQUENCE OF: (b) Carcinomatosis with ascites DUE TO, OR AS A CONSEQUENCE OF: (c) Elastic carcinoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION 11/12/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/25 , 19 68 , to 11/14 , 19 68 , that (I) (we) last saw the deceased alive on Nov. 14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles J. Foley Jr. M.D.				22c. DATE SIGNED 11/14/68			
22d. PHYSICIAN'S NAME (Type) CHARLES J. FOLEY JR. M.D.				22e. ADDRESS HAVRE DE GRACE, MD.			
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE 18 Nov 68		23c. NAME OF CEMETERY OR CREMATORY St Josephs Cemetery		23d. LOCATION (City or Town) (County) (State) Beaverdale, Penna	
24. FUNERAL DIRECTOR Barrring Funeral Home Aberdeen, Maryland Kenneth B. Gargy				25a. REC'D BY REGISTRAR NOV 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH

15970

159. 41

1 DECEASED NAME (Type or print)		First RUTH		Middle ELIZABETH		Last MASON		2a DATE OF DEATH Month Day Year November 17, 1968		2b AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH 6 March 1904		6. COUNTY OF DEATH Harford									
7a BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Harford									
10. CITY OR TOWN OF DEATH Aberdeen		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 143 Darlington Ave.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary		12b KIND OF BUSINESS OR INDUSTRY U.S. Govt.									
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 143 Darlington Ave.							
14. FATHER'S NAME First Middle Last James Cherry (D)		15. MOTHER'S MAIDEN NAME First Middle Last Louise Gerdorn (D)													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) No		16b SOCIAL SECURITY NO. 074-10-7563		17 INFORMANT Charlotte Neimark, Aberdeen, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA LIVER 11/10 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIO SCLEROTIC HEART DISEASE															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 7-8-68, 19 to 11-17-68, 19, that (I) (we) last saw the deceased alive on 11/13/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE B.J. Plunkett Jr.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-18-68					
22d. PHYSICIAN'S NAME (Type) B.J. Plunkett Jr.		22e. ADDRESS 617 W. Bel Air Ave. Aberdeen, Md. 21001													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 19 Nov. 68		23c. NAME OF CEMETERY OR CREMATORY St Georges Cemetery				23d. LOCATION (City or Town) (County) (State) Perryman, (Harford) Maryland							
24. FUNERAL DIRECTOR Walter W. W. W.		F. ADDRESS Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR DATE NOV 19 1968				25b. REGISTRAR'S SIGNATURE Charles J. Jones							



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5 and 6 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 15972. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2a F 15972
12/3/68
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
15972. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1998

1 DECEASED-NAME (Type or Print) Rosa Faye Newcomb		First Middle Last		2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Not Known 19		2b HOUR M	
3 SEX F	4 RACE W	5 DATE OF BIRTH 1-11-30	6 AGE (In years last birthday) 38 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month Nov Day 15 Year 1968	
7a BIRTHPLACE (State or foreign country) N.C.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford	
10 CITY OR TOWN OF DEATH Abingdon		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) waitress		12b KIND OF BUSINESS OR INDUSTRY Restaurant	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md		13b COUNTY Harford		13c CITY OR TOWN Abingdon		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME JHhn Oliver Crouse		First Middle Last		15 MOTHER'S MAIDEN NAME Jane Wooten		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16b SOCIAL SECURITY NO 231-32-9256		17. INFORMANT Berkley Alton Newcomb		ADDRESS Rt. 1 Box 446 Abingdon, Md.	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CSW L. CHEST 955X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 976X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 11-15 P.M. 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot self with shotgun			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No. City or Town County State Red Maple Dr. Edgewood Ht Md			
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gerald C Palmer		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 11-15-68	
EXAMINER'S NAME (Type) Gerald C Palmer		M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) 1301 A.M.	
23a BURIAL, CREMATION, REMOVAL (Specify) Removal		23b DATE Nov. 15, 1968		23c NAME OF CEMETERY OR CREMATORY Reins-Sturdivant		23d LOCATION (City or Town) (County) (State) Sparta Alleghany N.C.	
24 FUNERAL DIRECTOR Howard K. McComas & Son				ADDRESS Abingdon, Maryland		25a REC'D BY REGISTRAR DATE NOV 19 1968	
				25b REGISTRAR'S SIGNATURE G. C. Palmer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

15972		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15986	
Item #6, Film G406 11/20/68 km		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH	
ADDIE Evelyn		TARKS		NOV. Month 5 Day 1968	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		CAUCASIAN		8-21-1896	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Virginia		USA		9. COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
HARVE DE GRACE		BREVINS NURSING HOME		HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		HARFORD		BELAIR	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) (If yes give war or dates of service)	
JOHN WILEY CORNETT		ROSE (NOT KNOWN)		16b. SOCIAL SECURITY NO 220-54-7815	
17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
NURSING HOME RECORD CARD				PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Decomposition	
				(b) Hypertensive Cardiovascular Disease	
				(c) Arteriosclerosis	
				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 11/2: Gastroenteritis	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 9-10, 1968, to 11-5, 1968, that (I) (we) lost saw the deceased alive on 11-5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)	
Dante U. Monafil MD		11/6/68		DANTE U. MONAFIL	
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS	
211 N. Union Ave. Harve de Grace Md		211 N. Union Ave. Harve de Grace Md		211 N. Union Ave. Harve de Grace Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Nov 10, 1968		Cornett	
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR	
Archer Funeral Home		Baltimore Md.		DATE NOV 14 1968	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
Charles Judge		Charles Judge		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

15973		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15987	
Item#13e Film#G406 11/15/68 vm					
1 DECEASED NAME (Type or print) Nellie Krauss Patchell			2a. DATE OF DEATH Month November Day 7 Year 1968		2b. HOUR 1:35 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Aug. 17, 1934		6. AGE (In years last birthday) 34 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford Md	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House wife	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md COUNTY Cecil		13b. CITY OR TOWN Elkton	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER RD#5 Calverth Manor Nursg. Home	
14. FATHER'S NAME First Daniel I. Middle Krauss Last Krauss		15. MOTHER'S MAIDEN NAME First Martha Middle Wicks Last Wicks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT G. Clifton Patchell, Elkton, Md.	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bacterial Pneumonia 480X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) A.S.C.U.D. = Left Bundle Branch Block					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 10-27, 1968 , to 11-1, 1968 , that (I) (we) last saw the deceased alive on 11-1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Wm. O. ...		22c. DATE SIGNED Nov 1, 1968		22d. PHYSICIAN'S NAME (Type) Wm. O. ...	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-4-68		23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth.	
23d. LOCATION (City or Town) (County) (State) Elkton, Ce. Md.		24. FUNERAL DIRECTOR Wicks Funeral Home, Elkton, Md.		25a. REC'D BY REGISTRAR NOV 6 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

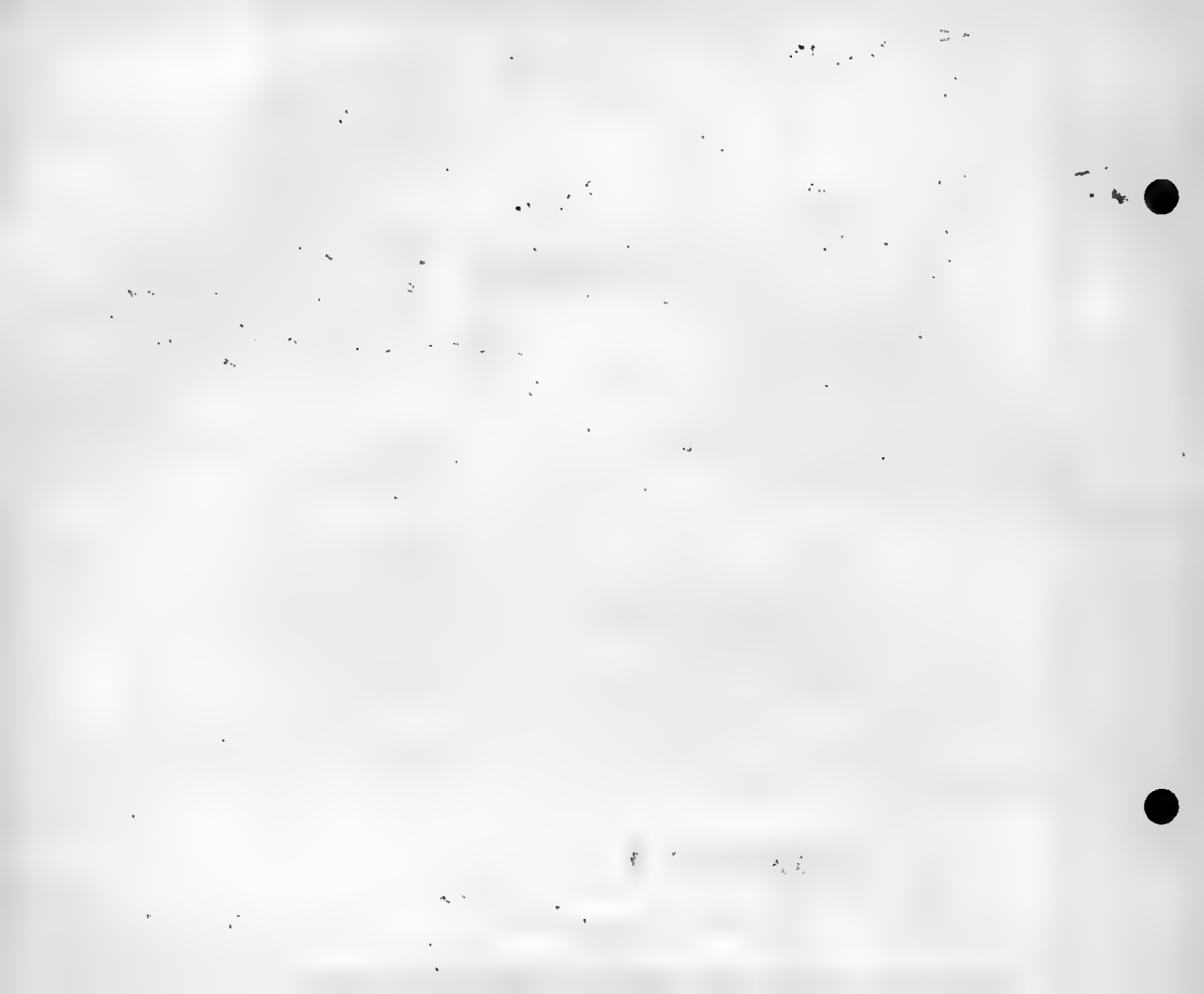
15974

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15988

1. DECEASED NAME (Type or print) <i>Ethel Porter Kammeyer</i>		2a. DATE OF DEATH Month <i>11</i> Day <i>18</i> Year <i>1968</i>		2b. HOUR M <i></i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>7/30/1895</i>	
7a. BIRTHPLACE (State or foreign country) <i>St. Michaels Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Landover Place</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Landover Place</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Prince Georges</i>		13c. STREET AND NUMBER <i>225 D. Washington</i>	
14. FATHER'S NAME First <i>John W.</i> Middle <i>Porter</i> Last <i></i>		15. MOTHER'S MAIDEN NAME First <i>Ann</i> Middle <i>Shelton</i> Last <i></i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i></i> (If yes give war or dates of service) <i></i>	
16b. SOCIAL SECURITY NO. <i>unk.</i>		17. INFORMANT <i>Landover Place Md</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolism</i> DUE TO, OR AS A CONSEQUENCE OF - (b) <i>Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>11</i> Day <i>18</i> Year <i>1968</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>11/11</i> , 19 <i>68</i> , to <i>11/18</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/18</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Irvin L. Wachsmann</i>		22c. DATE SIGNED <i>11/19/68</i>		22d. PHYSICIAN'S NAME (Type) <i>IRVIN WACHSMAN MD 8-8770-1-5</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>11/21/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill</i>	
24. FUNERAL DIRECTOR <i>Howard K. McComes</i>		25a. REC'D BY REGISTRAR <i>NOV 25 1968</i>		25b. REGISTRAR'S SIGNATURE <i>William S. Young</i>	



**FOR STATE
HEALTH DEPT.**

Item 2a Film 0137
12/3/68 kk
15975
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15989

1 DECEASED NAME (Type or Print) Lura Gay Pennington		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11 15 1968		2b HOUR M
3 SEX Female	4 RACE White	5. DATE OF BIRTH June 2, 1912	6. AGE (in years last birthday) 56 YRS	7 UNDER YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Tenn.		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Harford	13c CITY OR TOWN Bel Air	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Samuel Roark		15. MOTHER'S MAIDEN NAME First Middle Last Unknown Blevins		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO NONE		17 INFORMANT (Son) 838-5297 Mr. Cecil W. Pennington
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive CV Disease 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 440X				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE Gerald C. Palmer		CHIEF MED CAL EXAMINER <input type="checkbox"/> ASS STANT MED CAL EXAMINER <input type="checkbox"/> DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED Nov. 16, 1968
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		ADDRESS (Street, city, town, or county) S. Main St., Bel Air, Md. 21014		
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE Nov. 18, 1968	23c NAME OF CEMETERY OR CREMATORY Laurel Cemetery		23d LOCATION (City or Town) (County) (State) Bel Air, Harf. Co., Md. 21014
24 FUNERAL DIRECTOR Joseph William Foster		W. Broadway & Williams St. Bel Air, Maryland 21014		25a REC'D BY REGISTRAR DATE NOV 19 1968
		25b REGISTRAR'S SIGNATURE J. Charles Judge		

Joseph William Foster

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15989. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

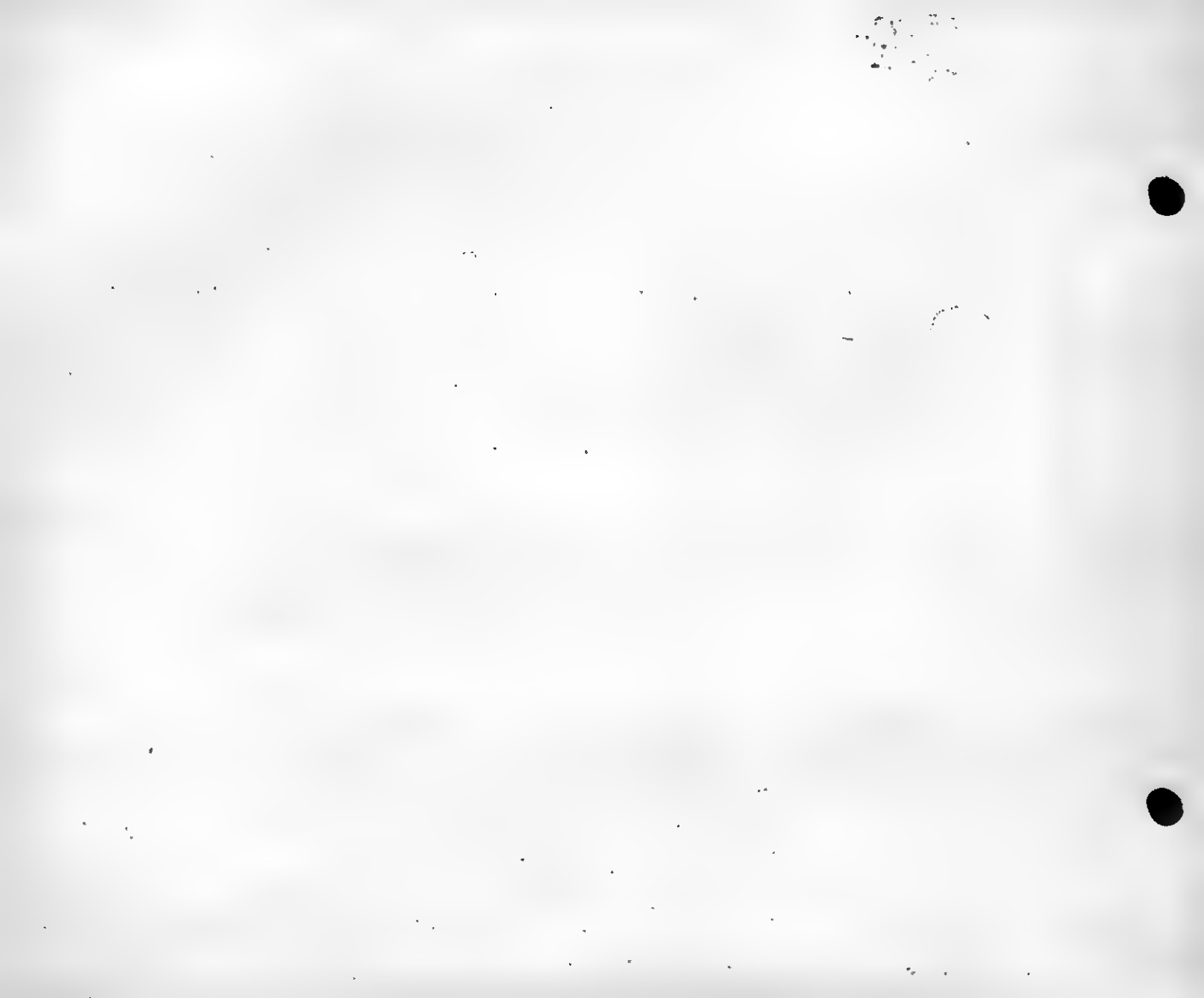
15976

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15890

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
					PRINCE	Nov Month 19 Day 19 Year 1968			2055 P.M.		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		NEGRO		NOV 19 1968		.0 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.			
MARYLAND		U.S.				HARFORD					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
A.P.G.			US KIRK ARMY Hosp			N/A			N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND			HARFORD		ABERDEEN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2730 D WATERLIET ST		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
NOT AVAILABLE			PAMELA			PRINCE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or of unknown			16b. SOCIAL SECURITY NO		17. INFORMANT			Address			
N/A			N/A		SPCHARNER L. PRINCE			SAME AS 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>PREMATURITY</u>										8 HOURS.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
N/A		N/A			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>19 NOV</u> , 19 <u>68</u> , to <u>19 NOV</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19 NOV</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
Carlos M. Del Valle, CTMC											19 Nov. 68.
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
CARLOS M. DEL VALLE, CTMC					US KIRK ARMY HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		11/22/68		Berkely Cemetery			Washington Harford Md				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Charles E. Buelink					HARFORD		NOV 29 1968				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and copy duly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M. REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Areese			Raine			Month 11 Day 21 Year 1968		M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		Negro		January 1, 1875		93 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md. Ala.		U. S. A.				Harford County, Md.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Harde Grace			801 Harfield Road			Housewife		Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm'ssion) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Harford		Harde Grace		YES		801 Harfield Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Robert			Childs			No Record				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
no			2B-52-0717-2		Mrs. Mary E. Daily, Harde de Grace, Md.		801 Harfield Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____										
DUE TO, OR AS A CONSEQUENCE OF _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF _____										
(c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
F. A. I.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		Lajos I. Mezei, M.D.			22c. DATE SIGNED					
		DEGREE ATTENDING PHYS 60 <input type="checkbox"/> S. DIRECTOR <input type="checkbox"/> M.D. <input type="checkbox"/> STAFF <input type="checkbox"/> APN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
		HARDE DE GRACE, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		11-26-1968		Berkley Cemetery		Baltimore Harford Co. Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Stephen J. Bullock, Harde de Grace, Md.		556 Lewis St.		DATE NOV 29 1968		J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
15978										
15992										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Wallis			Douglas Rogers			Nov. 2, 1968		9:02 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		04/08/05		63 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		USA				Harford				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace, MD.			Citizens Nursing Home			Carpenter		Carpentry		
13a. USUAL RESIDENCE (Where deceased lived, if institution an admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Bel Maryland			Harford		Bel Air Newark		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		516 Rock Spring Ave. 912 Picket Lane	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Wallis O. Rogers			Lila Irene Everest							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT (Name, address, and relationship)					
No			215-09-5013		Mrs. Patricia R. Younger 912 Picket Lane Newark, Del. - Dec 1971					
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>infection of obstructing</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>edema carcinoma, rectum</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
									3 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Monday Cinema 4</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
5/5/67		Ca. Rectum								
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from May, 1967, to Nov, 1968, that (I) (we) last saw the deceased alive on Nov 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. Ralph Horley</u>					22c. DATE SIGNED <u>11/5/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Dr. Ralph Horley</u>					22e. ADDRESS <u>Churchville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Nov. 5, 1968		Bel Air Memorial Gardens		Bel Air, Harford Co., Maryland 21014				
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>					25a. REG. BY REG. STAMP DATE <u>NOV 6 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 44-101
30M REV. 11-68

15979

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

159 3

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Pluma Bell Scott			2a. DATE OF DEATH Month 11 Day 7 Year 68			2b. HOUR 5A					
3 SEX Female		4. RACE White		5. DATE OF BIRTH APR. 4, 1901		6. AGE (In years last birthday) 67 YRS		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD					
10. CITY OR TOWN OF DEATH Harre-de-Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.			13b. COUNTY Cecil			13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER MT. ARROT FARMS	
14. FATHER'S NAME First John Middle Masten Last Annie			15. MOTHER'S MAIDEN NAME First Flukey Middle Flukey Last Flukey								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 220-16-9664			17. INFORMANT HOSPITAL RECORDS			Address HAUREDEGRACE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Dehydration DUE TO, OR AS A CONSEQUENCE OF Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 332X (b) Cerebrovascular Accident (Thrombosis) DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus (Incidental finding)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-31, 1968 , to 11-1, 1968 , that (I) (we) last saw the deceased alive on 11-1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dante U. Monakil, M.D. DEGREE MD						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 11/1/68		
22d. PHYSICIAN'S NAME (Type) DANTE U. MONAKIL						22e. ADDRESS 211 N. Union Ave. Harre-de-Grace Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE NOV. 4, 1968			23c. NAME OF CEMETERY OR CREMATORY DENTON CEMTY			23d. LOCATION (City or Town) (County) (State) DENTON CAROLINE MD.		
24. FUNERAL DIRECTOR VICTOR N. KENNEDY						ADDRESS STILL FOND, MD.			25a. REC'D BY REGISTRAR NOV 6 1968		
									25b. REGISTRAR'S SIGNATURE J. Charles Judge		

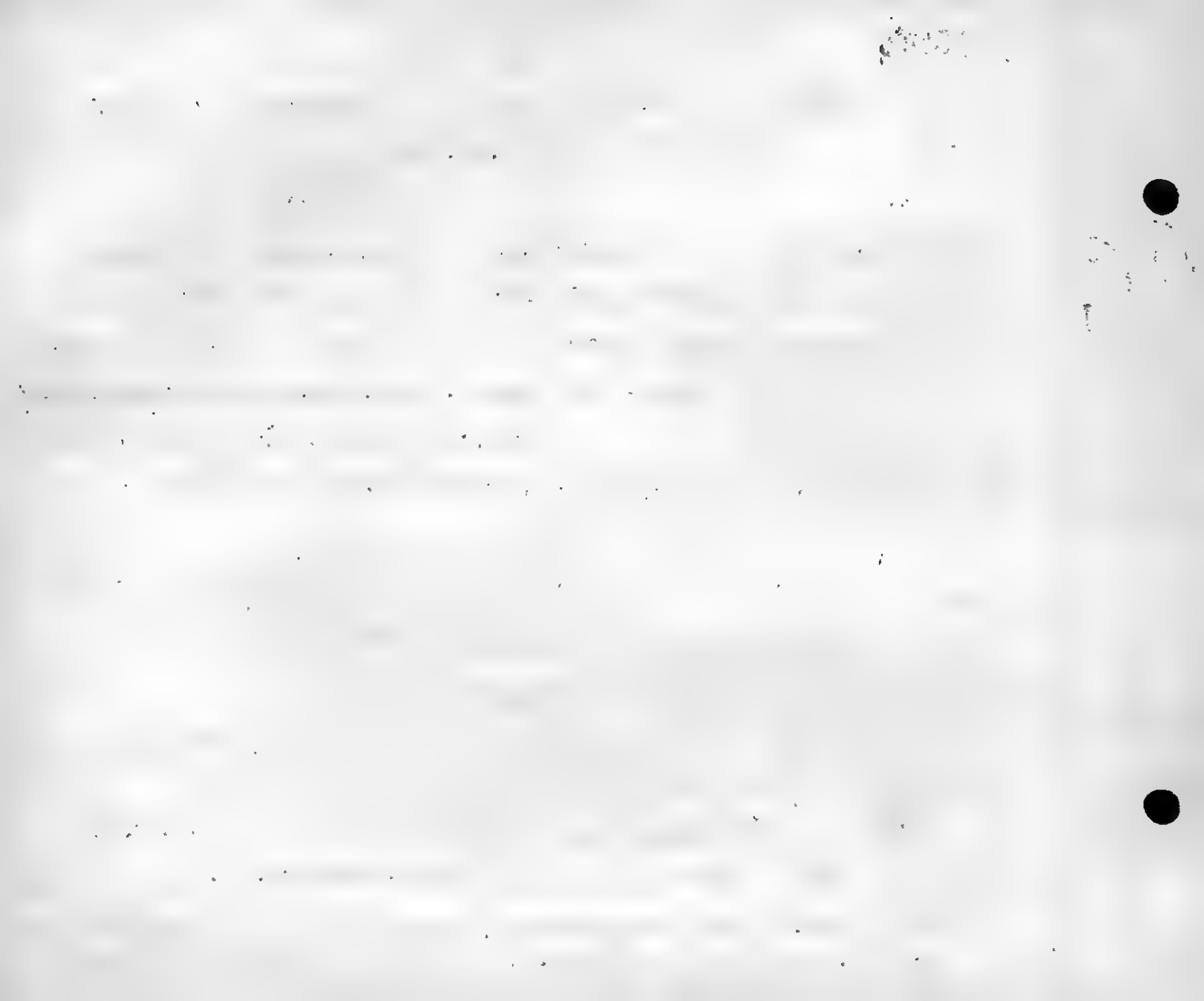


15980

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or removal, and transfer event, within 72 hours after death.

1. DECEASED-NAME (Type or print) RAYMOND JAMES SCOTT			2a. DATE OF DEATH Month November Day 27 Year 1968			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 6, 1912		6. AGE (In years last birthday) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford			
10. CITY OR TOWN OF DEATH Churchville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bramble Lane		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auto mechanic		12b. KIND OF BUSINESS OR INDUSTRY garage			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Bramble Lane	
14. FATHER'S NAME First Walter Middle Francis Last Scott			15. MOTHER'S MAIDEN NAME First Anna Middle A. Last Poine						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 214-18-7199		17. INFORMANT Address Naomi T. Scott, Bramble Lane, Churchville, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion of Terminal 4109 DUE TO, OR AS A CONSEQUENCE OF Coronary arteriosclerosis & insufficiency 54r- (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Rheumatic heart disease, aortic & mitral regurg, aortic. Rb/11									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-24-1952 to 11-27-1968 , that (I) (we) last saw the deceased alive on 11-18-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Peter P. Rodman, M.D.		22c. DATE SIGNED Nov. 29, 1968		22d. PHYSICIAN'S NAME (Type) Peter P. Rodman					
22e. ADDRESS 8 Law St., Aberdeen, Md.									
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial		23b. DATE Nov. 30, 1968		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md			
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		25a. REC'D BY REGISTRAR DEC 2 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
15982										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>ReTha Irene Scott</i>					2a. DATE OF DEATH			2b. HOUR		
					Month <i>11</i> Day <i>27</i> Year <i>68</i>			5:30 PM		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>APR. 9 1898</i>		6 AGE (in years last birthday) <i>70</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.				
10. CITY OR TOWN OF DEATH <i>Harrods-Grace</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSE WIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Street</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>R. D. # 1</i>	
14 FATHER'S NAME First <i>Walter Thomas</i> Middle <i>Allen</i> Last <i>Allen</i>					15 MOTHER'S MAIDEN NAME First <i>Minnie</i> Middle <i>Mc Coy</i> Last <i>Mc Coy</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>			16b. SOCIAL SECURITY NO. <i>234-78-9760</i>		17 INFORMANT <i>Ruth Rudd. same as pt.</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebral Vascular Thrombosis</i> 41									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>17 days</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>A. S. C. V. D.</i>									2 years	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4221</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BLT. NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town. County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>11/27</i> , 19 <i>68</i> , to <i>11/27</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Edward C. Loo, M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>7/27/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>					22e. ADDRESS <i>Harrods-Grace, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>Nov 30, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WHITING CEM.</i>		23d. LOCATION (City or town) (County) (State) <i>DROOMPT. BOCAHONTAS CO. W. VA.</i>				
24 FUNERAL DIRECTOR <i>R. Madison Mitchell, Harrods-Grace, Md.</i>					25a. REC'D BY REGISTRAR <i>DEC 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15982

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Jane Sarah Sheppard.			2a. DATE OF DEATH Month 11 Day 1 Year 68			2b. HOUR 6 P M	
3 SEX Female		4. RACE Negro		5. DATE OF BIRTH March 17, 1897		6 AGE (in years lost birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD	
10. CITY OR TOWN OF DEATH Harre de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook		12b KIND OF BUSINESS OR INDUSTRY Diner	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md		13b COUNTY Harford		13c CITY OR TOWN Shepherd		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Lloyd Middle Scornion Last Scornion		15 MOTHER'S MAIDEN NAME First Harriett Middle Ann Last Tasco					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO 219-01-3186		17 INFORMANT Ms. Wendell Sheppard, Aberdeen, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4120 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive - Arteriosclerotic C.V. disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus & Vascular Insufficiency of lower Ext.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-1 , 19 68 , to 11-1 , 19 68 , that (I) (we) last saw the deceased alive on 11-1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George T. Stansbury M.D.				22c. DATE SIGNED 11/2/68			
22d. PHYSICIAN'S NAME (Type) George T. Stansbury, M.D.				22e. ADDRESS 569 Revolution St. Harre de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-6-68		23c. NAME OF CEMETERY OR CREMATORY Berkley Cemetery		23d. LOCATION (City or Town) (County) (State) Darlington, Harford, Md.	
24. FUNERAL DIRECTOR Charles J. Bullock, Harre de Grace, Md.				25a. REC'D BY REGISTRAR DATE NOV 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

1977



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15983

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <i>Vida Fidelia Simmers</i>			2a. DATE OF DEATH Month Day Year <i>Nov. 8 1968</i>			2b. HOUR <i>12:20</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Feb. 1, 1896</i>		6. AGE (In years last birthday) <i>72</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i>			
10. CITY OR TOWN OF DEATH <i>HARFORD</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Port Deposit</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>RD #1 - Hopewell Rd.</i>	
14. FATHER'S NAME First Middle Last <i>James Hilton</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Florence Becraft</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Gilbert Simmers</i>		Address <i>Port Deposit Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Pancreas & Stomach</i> <i>1940</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>199</i>									
19a. DATE OF OPERATION <i>199</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 1968, to <i>Nov 7</i> , 1968, that (I) (we) last saw the deceased alive on <i>Nov 8</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Clarence J. Benson</i>				DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>Nov 8-1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>CLARENCE J. BENSON</i>				22e. ADDRESS <i>Port Deposit, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-10-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Port Deposit Cecil Md.</i>			
24. FUNERAL DIRECTOR <i>Edmond M. Mullen</i>				ADDRESS <i>Rising Sun, Md.</i>		25a. REC'D BY REGISTRAR <i>NOV 14 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARTIN LUTHER KING, JR. DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15984 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) BARBARA JOSEPHINE SOKOL					2a. DATE OF DEATH Month November , Day 7 , Year 1968		2b. HOUR 4:15 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 19 April 1915		6. AGE (in years last birthday) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? Germany		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford		Md.	
10. CITY OR TOWN OF DEATH Aberdeen			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY 	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. CITY OR TOWN Residence before Harford		13c. CITY OR TOWN APG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2764-E Rodman Road	
14. FATHER'S NAME First JOHANN Middle NONE Last WILD			15. MOTHER'S MAIDEN NAME First ROSA Middle NONE Last GISCHEK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 213-46-3129		17. INFORMANT SSG JOHN SOKOL		Address Same as 13A B R a			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Unknown DOA									
DUE TO, OR AS A CONSEQUENCE OF Unknown									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF Unknown									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 11/12/68									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day 19 Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 					
22a. I certify that (I) (this hospital) attended the deceased from , 19 , to , 19 , that (I) (we) lost saw the deceased alive on , 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE F. S. Williams				22c. DATE SIGNED 7 November 1968					
22d. PHYSICIAN'S NAME (Type) F. S. Williams				22e. ADDRESS US Kirk Army Hospital, APG, Md. 21005					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/12/1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) St. Meyer Virginia			
24. FUNERAL DIRECTOR Walter W. Coleman Jr.				25a. REC'D BY REGISTRAR Tarney Federal House		25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE NOV 13 1968	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15985

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15999

1 DECEASED NAME (Type or Print) Phillip Lee Townsend			2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR NOT KNOWN <input type="checkbox"/> 19			2b HOUR M			
3 SEX Male	4 RACE White	5 DATE OF BIRTH Feb 27, 1914	6 AGE (in years last birthday) 54 YRS	IF UNDER YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year March 2 1968			2d HOUR M
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford County,			Md
10 CITY OR TOWN OF DEATH Bel Air		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 109 Idlewild Street			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Carpenter		12b KIND OF BUSINESS OR INDUSTRY Construction		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Dorchester		13c CITY OR TOWN Cambridge		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 429 Robbins Street
14. FATHER'S NAME First Middle Last John David Townsend			15. MOTHER'S MAIDEN NAME First Middle Last Carrie Beatrice Hudson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 220-10-6584		17. INFORMANT ADDRESS 429 Robbins St., Mrs. Louella W. Townsend, Cambridge, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Gerald C. Palmer			CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.			22b. DATE SIGNED			
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Nov. 2, 1968			
ADDRESS (Street, city, town, or county) S. Main St., Bel Air, Md. 21014									
23a BURIAL, CREMATION, OR OTHER DISPOSITION Burial		23b DATE Nov. 4, 1968		23c NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park, Cambridge, Dor. Md.		23d LOCATION (City or Town) (County) (State) Cambridge, Md.			
24. FUNERAL DIRECTOR James A. Howard				ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



15986

CERTIFICATE OF DEATH

16000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Street		c. LENGTH OF STAY IN 1b 40Yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Street		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First WILLIAM Middle S. Last TROUT		4 DATE OF DEATH Month Nov. Day 21 , Year 19 68	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/22/1902
9 AGE (In years lost birthday) yrs 65		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Trout		14. MOTHER'S MAIDEN NAME Mary Slade	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-36-4267	
17 INFORMANT Mrs. Imo H. Trout, Street, Maryland		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1538 IMMEDIATE CAUSE (a) Internal Hemorrhage DUE TO (b) Carcinomatous - Primary in Colon. DUE TO (c) 4 months		INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1539 Coronary sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to Nov 21, 1968 , that (I) (we) last saw the deceased alive on Nov 20, 1968 , and that death occurred at 2:10 PM on Nov 21, 1968 , from causes and on the date stated above.			
22a. SIGNATURE Josiah A. Hunt, M.D.		22b. DATE SIGNED Nov. 22 1968	
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt, M.D.		22d. ADDRESS Delta, Penna. 17314	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/68	
23c. NAME OF CEMETERY OR CREMATORY Fawn Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Fawn Grove, York Co., Pa.	
24. FUNERAL DIRECTOR Kenneth W. Oshum		25a. REC'D BY REGISTRAR Nov 25 1968	
ADDRESS Stewartstown, Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in space 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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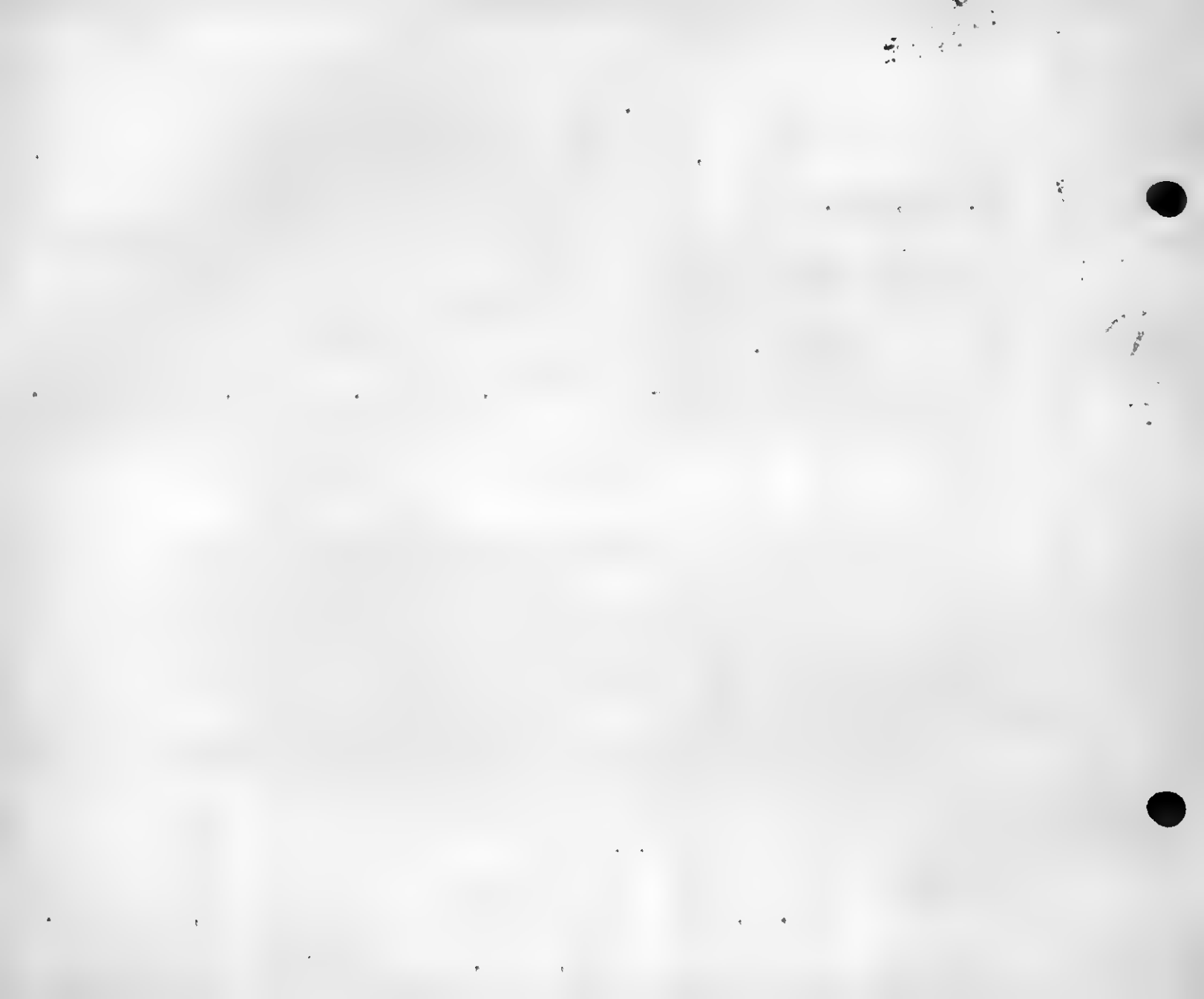
15987

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16001

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF EST DEATH MATED <input checked="" type="checkbox"/> 11/10 1968			2b HOUR 8:00 A.M.
PAUL K. WALLACE									
3 SEX male	4 RACE white	5 DATE OF BIRTH May 31, 1906	6 AGE (In years last birth)	62 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD November 10, 1968		2d HOUR 10:00 A.M.
7a BIRTHPLACE (State or foreign country) Mt. City, Tenn.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Harford Md.				
10 CITY OR TOWN OF DEATH Darlington			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Castleton Road			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Custodian		12b KIND OF BUSINESS OR INDUSTRY Public School	
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Harford		13c CITY OR TOWN Darlington		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Castleton Road
14. FATHER'S NAME First Middle Last Roby F. Wallace					15. MOTHER'S MAIDEN NAME First Middle Last Mollie Gentry				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO (If yes give war or dates of service) 218-14-8070		17 INFORMANT ADDRESS Mrs. Julia M. Wallace, Darlington, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4127 DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4127									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town or county)		22b DATE SIGNED 11/11/68	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Nov. 13, 1968		Darlington		Darlington, Harford Md.			
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE	
JOHN H. HARKINS			Delta, Penna.			DATE NOV 14 1968		f Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15988		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16002	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) CLARENCE First VINCENT Middle WATKINS Last			2a. DATE OF DEATH Nov Month 29 Day 68 Year			2b. HOUR 7:45 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 16, 1905		6. AGE (In years last birthday) 63 YRS.	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARford Md.	
10. CITY OR TOWN OF DEATH HAVER de GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARford Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Welding	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. CITY OR TOWN Balto.		13c. CITY OR TOWN Kingsville		13d. STREET AND NUMBER Cedar Lane	
14. FATHER'S NAME First ISAAC Middle Elias Last WATKINS		15. MOTHER'S MAIDEN NAME First LAURA Middle Seese Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 176-09-6865	
17. INFORMANT Mrs. Margaret M. Watkins		Address Cedar Lane, Kings-				Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Rupture of myocardium DUE TO, OR AS A CONSEQUENCE OF (c) Anterolateral myocardial infarction, one week PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) 4201				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-23, 1968 , to 11-29, 1968 , that (I) (we) last saw the deceased alive on 11-29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward C. Loo, M.D.				22c. DATE SIGNED 11/29/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Haver de Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Dec. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air HARford Md	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a. REC'D BY REGISTRAR DEC 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

12/6/68 11:10 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16003	
Item 5 Film G 407 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME First Middle Last 15589 Wilford W Zellman						2a. DATE KNOWN OF DEATH ESTIMATED Month Day Year Nov. 30, 1968			2b. HOUR M 8:45 P.M.		
3. SEX M		4. RACE W		5. DATE OF BIRTH 12/11/1948		6. AGE (In years last birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS NOV 30 1968		IF UNDER 24 HRS. HOURS MIN. NOV 30 1968	
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Harford				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY WOOD CUTTER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD				13b. COUNTY HARFORD		13c. CITY OR TOWN DARLINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER STAFFORD ROAD	
14. FATHER'S NAME First Middle Last FRED H. ZELMAN						15. MOTHER'S MAIDEN NAME First Middle Last MARTHA I. MITCHELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16b. SOCIAL SECURITY NO. 219-10-9481		17. INFORMANT Mr. Carrie Louise Zellman				ADDRESS STAFFORD RD DARLINGTON MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8354											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. Nov 30 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Auto Accident					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Level Road			21f. LOCATION Street or R.F.D. No. City or Town County State Harford Harford Co. Md.						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Gerald C Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/> Be/Air, Md.				22b. DATE SIGNED 12-1-68			
EXAMINER'S NAME (Type) Gerald C Palmer MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE DEC. 3 1968		23c. NAME OF CEMETERY OR CREMATORY Rock Run Cem.			23d. LOCATION (City or Town) (County) (State) HARFORD Co. MD.			
24. FUNERAL DIRECTOR R. Madison Mitchell, Harford Co., Md.						25a. REC'D. BY REGISTRAR DATE DEC 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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